

**Site visit inspection report on performance against HTA quality standards  
Royal Cornwall Hospital  
HTA licensing number 12208**

**Licensed under the Human Tissue Act 2004 for the:**

- **making of a post mortem examination;**
- **removal from the body of a deceased person (otherwise than in the course of an anatomical examination or post mortem examination) of relevant material of which the body consists or which it contains, for use for a scheduled purpose other than transplantation; and**
- **storage of the body of a deceased person or relevant material which has come from a human body for use for a scheduled purpose**

**21 July 2011**

**Executive Summary**

A site visit inspection of the Royal Cornwall Hospital (the establishment) was carried out by the HTA on 21 July 2011.

The establishment was found to meet many of the HTA standards, however, some shortfalls were found across the areas of: consent; governance and quality; and premises, facilities and equipment. Any particular examples of strengths or good practice are included in the concluding comments section of the report.

The HTA found the Designated Individual, the Licence Holder, the premises and the practices to be suitable in accordance with the requirements of the legislation.

All reports of HTA inspections carried out from 1 November 2010 are published on the HTA's website.

## **Background to the establishment and description of inspection activities undertaken**

Royal Cornwall Hospital (the establishment) is based in Treliske, near Truro in Cornwall. It undertakes approximately 1500 post mortems per year, nearly all under the jurisdiction of the Cornwall Coroner. Approximately 20 consented hospital post mortems are conducted annually. The establishment does not undertake paediatric post mortems; however, tissue may be taken from deceased children, normally a skin biopsy for cytogenetic analysis, in four areas of the hospital related to paediatric care. The establishment does not conduct post mortem examinations where there is a known high risk of infection.

Following post mortem examination, tissue taken from bodies may be stored for a scheduled purpose in the histology laboratory or in a dedicated storage facility on the hospital premises.

This is the second inspection that the HTA has made of the establishment. The first was in February 2008. Special attention was given to systems of traceability and documentation relating to the retention of tissue samples. A traceability audit was undertaken of two bodies stored in the mortuary against records; no anomalies were found. Inaccurate records were found relating to tissue slides retained in the histology laboratory; there were two errors found in the seven post mortem cases checked. More information is provided against standard GQ6 below.

All areas of the establishment were inspected, including the Intensive Therapy Unit, the Emergency Department, the Neonatal Unit, the Wheal Rose Ward (all areas where tissue may be removed post mortem in paediatric cases), the Mortuary and Post Mortem Examination Suite and the Histopathology and Cytopathology Departments. The inspection included a review of documentation supporting licensable activities and interviews with key members of staff and the Cornwall Coroner.

## **Meeting the HTA's licensing standards**

The HTA developed its licensing standards with input from its stakeholders, in order to ensure the safe and ethical use of human tissue and the dignified and respectful treatment of the deceased. The HTA expects licensed establishments to meet these standards.

This is an exception-based report: only those standards that have been assessed as not met are included. Where the HTA determines that a licensing standard is not met, the level of the shortfall will be classified as 'Critical', 'Major' or 'Minor' (see Appendix 3: Classification of the level of shortfall).

**Unless otherwise advised, the establishment is required to inform the HTA within 14 days of the receipt of the final report of the corrective and preventative actions that will be taken to ensure that the improvements are addressed.** A template for this purpose is provided as a separate Word document.

## HTA standards not met

### Consent

Standard	Inspection findings	Level of shortfall
C1 Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the Code of Practice.	The form used to record consent for hospital post mortems informs that it is normal practice to retain tissue blocks and slides as a permanent record, and consenters are asked to agree that they can be stored in the archives. Therefore, fully informed consent for storage of these samples is not being obtained.	Minor
C2 Information about the consent process is provided and in a variety of formats.	The written information provided is an out-dated NHS leaflet and contains inappropriate information. For example, it states that tissue blocks and slides will be stored routinely, whereas this may only be undertaken with consent.	Minor
C3 Staff involved in seeking consent receive training and support in the implications and essential requirements of taking consent.	Those seeking consent for adult hospital post mortems are not always adequately trained. There is a lack of awareness of the procedure for taking consent for Post Mortem (PM) examination, and members of staff are unaware of who has received training.	Minor

### Governance and Quality

Standard	Inspection findings	Level of shortfall
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.	Some written procedures used in the establishment do not clearly demonstrate document control, in that they lack information regarding authorship and ratification, version control, and periodic review.	Minor

<p>GQ6 A coding and records system facilitates traceability of bodies, body parts, tissues and cells, ensuring a robust audit trail.</p>	<p>Inaccurate records were found relating to tissue slides retained in the histology laboratory. There were two errors found in the seven post mortem cases checked. In one case an additional slide had not been recorded. In a second case records were kept of 15 slides that had never been made; on further investigation, the HTA established that, although requested, it was not possible to make the slides from the wax block but this information had not been recorded on the histopathology database, which therefore contained inaccurate information about tissue retention.</p> <p>An electronic record of the disposal of tissue blocks and slides fails to record how many samples have been incinerated. Paper slips indicate removal of blocks and slides from their storage locations, however these are not adequate records of disposal.</p> <p>The establishment is at risk of losing track of retained relevant material because members of staff do not properly maintain records of traceability. This risk has not been assessed with a view to remedial actions being taken.</p> <p>There is a combination of several minor shortfalls against this standard, none of which is major on its own, but which, together, constitute a major shortfall.</p>	<p><b>Major</b></p>
<p>GQ7 There are systems to ensure that all adverse events, reactions and / or incidents are investigated promptly.</p>	<p>There is no written procedure for identifying notifiable serious untoward incidents. Written procedures state that the HTA should be notified when a serious untoward incident occurs, but they lack detail regarding how this should be done and who has responsibility.</p>	<p><b>Minor</b></p>
<p>GQ8 Risk assessments of the establishment's practices and processes are completed regularly and are recorded and monitored appropriately.</p>	<p>There has been no documented risk assessment of the practice of Anatomical Pathology Technologists identifying the deceased, completing an external examination and eviscerating the body prior to a pathologist attending the mortuary. This practice is contrary to The Royal College of Pathologists (RCPath) guidance and, if it is to be continued, should be risk assessed and documented in a standard operating procedure, which states clearly the circumstances in which preparation of the body would not take place without the pathologist first examining the body.</p>	<p><b>Minor</b></p>

## Premises, Facilities and Equipment

Standard	Inspection findings	Level of shortfall
PFE1 The premises are fit for purpose.	<p>The premises of the mortuary are not in reasonable condition. Door surrounds within the body store transitory area are broken, and the doors to the post mortem suite do not close properly and are unsuitable.</p> <p>These shortfalls present security and health and safety risks, in addition to a risk to public confidence in the establishment.</p>	<b>Major</b>

## Advice

Below are matters which the HTA advises the DI to consider.

No.	Standard	Advice
1.	PFE2	The HTA advises the DI to establish a schedule for cleaning the body storage facilities, and to ensure that this cleaning is recorded.

## Concluding comments

The establishment was found to meet many of HTA standards, however, some shortfalls were found across in the areas of: consent; governance and quality; and premises, facilities and equipment.

The HTA found the Designated Individual, the Licence Holder, the premises and the practices to be suitable in accordance with the requirements of the legislation.

During the inspection the HTA noted that bodies in the mortuary were shrouded at all times, however 10% did not have their faces covered following on from a Coroners examination. The establishment made immediate changes to policies and protocols to ensure that all bodies are covered including their faces.

The HTA found areas of good practice at the establishment. Examples are listed below.

- Strong communication channels have been established with the coroner's office. This ensures that the establishment's members of staff are informed promptly of the wishes of properly interested persons with respect to retained tissue, following the end of the coroner's jurisdiction in coronial post mortem cases.
- The establishment has a mature quality manual, which includes a documented system of audit.
- Security is good throughout the establishment, with the use of swipe card access to secure areas, and closed circuit television recording for the mortuary body store area.
- A separate dedicated fridge is used to store deceased infants.

**Report sent to DI for factual accuracy: 8 August 2011**

**Report returned from DI: 22 August 2011**

**Final report issued: 02 September 2011**

**Completion of corrective and preventative actions (CAPA) plan**

Based on information provided, the HTA is satisfied that the establishment has completed the agreed actions in the CAPA plan.

Date: 13 December 2011

## Appendix 1: HTA inspection process

The Human Tissue Authority regulates the removal, storage, and use of human bodies, body parts, organs and tissue for activities such as research, transplantation, and education and training. The legal requirements for establishments which carry out such activities are set out in the Human Tissue Act 2004 and The Human Tissue Act 2004 (Ethical Approval, Exceptions from Licensing and Supply of Information about Transplants) Regulations 2006.

We license establishments in England, Wales and Northern Ireland that carry out these activities, and inspect them to make sure legal requirements are met.

### Inspections

We use the term 'inspection' to describe when we:

- visit an establishment to meet with staff, view premises and facilities, and review policies and procedures (a site-visit inspection); or
- assess written information we have requested from an establishment (a desk-based assessment / inspection).

We carry out inspections to assess if the Designated Individual (DI) is suitable to supervise the activity covered by the licence, as it is their responsibility to ensure that:

- other staff working under the licence are suitable;
- suitable practices are used when carrying out the activity; and
- the conditions of the licence are met.

We also need to be satisfied that the licence applicant or holder, the establishment's premises, and the practices relating to licensed activities, are suitable.

To help us reach our decisions, we have developed standards under four headings: Consent; Governance and Quality; Premises, Facilities and Equipment; and Disposal.

After every site visit inspection, we write a report documenting our findings. Where we find a particular standard is not fully met, we will describe the level of the shortfall as 'Critical', 'Major' or 'Minor'. In most cases, it will be the responsibility of the DI to seek the HTA's agreement on how they will address the identified shortfalls. More information about the classification of shortfalls can be found in Appendix 3.

The majority of our site-visit inspections are announced. If we have concerns about an establishment, we can also undertake an unannounced site visit inspection.

You can find reports for site visit inspections which took place after 1 November 2010 on our website.

## Appendix 2: HTA standards

Standards which are not applicable to this establishment have been highlighted.

Consent standards
<b>C1 Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the code of practice</b>
<ul style="list-style-type: none"><li>• There is a documented policy which governs consent for post-mortem examination and the retention of tissue and reflects the requirements of the HT Act and the latest version of the HTA Code of Practice on consent.</li><li>• There is a documented SOP detailing the consent process (including who is able to take consent, what training they must receive, and what information must be provided to those giving consent for post-mortem examination).</li><li>• There is written information about the consent process (provided to those giving consent), which reflects the requirements of the HT Act and the latest version of the HTA Code of Practice on consent.</li></ul>
<b>C2 Information about the consent process is provided and in a variety of formats</b>
<ul style="list-style-type: none"><li>• Relatives are given an opportunity to ask questions.</li><li>• Relatives are given an opportunity to change their minds and it is made clear who should be contacted in this event.</li><li>• Information contains clear guidance on options for how tissue may be handled after the post-mortem examination (repatriated with the body, returned to the family for burial/cremation, disposed of or stored for future use).</li><li>• Where consent is sought for tissue to be retained for future use, information is provided about the potential uses in order to ensure that informed consent is obtained.</li><li>• Information on the consent process is available in different languages and formats, or there is access to interpreters/translators.</li></ul>
<b>C3 Staff involved in seeking consent receive training and support in the implications and essential requirements of taking consent</b>
<ul style="list-style-type: none"><li>• There is a training programme for taking consent for post-mortem examination and tissue retention which addresses the requirements of the HT Act and HTA code of practice on consent.</li><li>• Refresher training is available (e.g. annually).</li><li>• Attendance at consent training is documented.</li><li>• If untrained staff are involved in consent taking, they are always accompanied by a trained individual.</li></ul>

## Governance and quality system standards

### GQ1 All aspects of the establishments work are supported by ratified documented policies and procedures as part of the overall governance process

- Documented policies and SOPs cover all mortuary/laboratory procedures relevant to the licensed activity. These may include:
    - post-mortem examination, including the responsibilities of the APTs and Pathologists (e.g. evisceration) and management of high risk cases
    - record keeping
    - receipt and release of bodies, which reflect out of hours arrangements
    - lone working in the mortuary
    - transfer of bodies and tissue (including blocks and slides) to other establishments or off site
    - ensuring that tissue is handled in line with documented wishes of the relatives
    - disposal of tissue (including blocks and slides)
- (Note that individual SOPs for each activity are not required. Some SOPs will cover more than one activity.)*
- Policies and procedures are regularly reviewed (for example, every 1-3 years).
  - There is a system for recording that staff have read and understood the latest versions of these documents.
  - Deviations from documented SOPs are recorded and monitored.

### GQ2 There is a documented system of quality management and audit

- There is a quality manual which includes mortuary activities.
- Policies and SOPs are version controlled (and only the latest versions available for use).
- There is a schedule for audits to be carried out (which may include vertical and/or horizontal audits).
- Audits include compliance with documented procedures, records (for completeness) and traceability.
- Audit findings document who is responsible for follow up actions and the timeframe for completing those actions.
- Regular audits of tissue being stored at the establishment ensure that staff are fully aware what material is held and why.
- There is a complaints system in place.

### GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills

- Staff are appropriately trained/qualified or supervised.
- Staff have annual appraisals.
- Staff are given opportunities to attend training courses, either internally or externally.
- Attendance by staff at training events is recorded.

- There is a documented training programme for new mortuary staff (e.g. competency checklist).

**GQ4 There is a systematic and planned approach to the management of records**

- There is a system for managing records which includes which records must be maintained, how they are backed up, where records are kept, how long each type of record is retained and who has access to each type of record.
- There are documented SOPs for record management.

**GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.**

**GQ6 A coding and records system facilitates traceability of bodies, body parts, tissues and cells, ensuring a robust audit trail**

- Bodies are tagged/labelled upon arrival at the mortuary.
- There is a system to track each body from admission to the mortuary to release for burial or cremation (e.g. mortuary register, patient file, transport records).
- Organs or tissue taken during post mortem examination are fully traceable, including blocks and slides. The traceability system ensures that the following details are recorded:
  - material sent for analysis on or off-site, including confirmation of arrival
  - receipt upon return to the laboratory or mortuary
  - number of blocks and slides made
  - repatriation with a body
  - return for burial or cremation
  - disposal or retention for future use.
- Multiple identifiers used, including at least one unique identifier (e.g. post mortem number, name, dates of birth/death, etc) to identify bodies and tissue.

**GQ7 There are systems to ensure that all adverse events, reactions and / or incidents are investigated promptly**

- Staff are trained in how to use the incident reporting system.
- Staff know how to identify incidents and near-misses which must be reported, including those that must be reported to the HTA
- The incident reporting system clearly outline responsibilities for reporting, investigating and follow up for incidents.
- The incident reporting system ensures that follow up actions are identified (i.e. corrective and preventative actions) and completed.
- Information about incidents is shared with all staff (including the reporter) to avoid repeat errors.

**GQ8 Risk assessments of the establishment's practices and processes are completed regularly and are recorded and monitored appropriately**

- All procedures related to the licensed activities (as outlined in standard GQ1) are risk assessed.
- Risk assessments include risks associated with non-compliance with HTA standards as well as health and safety risks.
- Risk assessments are reviewed regularly (along with SOPs), for example every 1-3 years.
- Risk assessments include how to mitigate the identified risks; this includes actions that need to be taken, who is responsible for each action, deadlines for completing actions and confirmation that actions have been completed.

**Premises, facilities and equipment standards**

**PFE1 The premises are fit for purpose**

- There is sufficient space for the activities to be carried out.
- Refrigerated storage units are in good working condition and well maintained.
- Surfaces are made of non-porous materials.
- The premises are in reasonable condition (structure and cleanliness of floors, walls, entranceways).
- The premises are secure (e.g. there is controlled access to bodies, tissue, equipment and records).

**PFE 2 Environmental controls are in place to avoid potential contamination**

- There is clear separation of clean, transitional and dirty zones (e.g. doors, floor markings, signs).
- There is appropriate PPE available and routinely worn by staff.
- There is adequate critical equipment and/or PPE available for high risk post mortems.
- There are documented cleaning and decontamination procedures.
- There are documented cleaning schedule and records of cleaning and decontamination.

**PFE3 There are appropriate facilities for the storage of bodies, body parts, tissues and cells, consumables and records.**

- There is sufficient capacity for storage of bodies, organs and tissues.
- Temperatures of fridges and freezers are monitored on a regular basis.
- There are documented contingency plans in place should there be a power failure, or overflow.
- Bodies are shrouded whilst in storage.
- There is separate storage for infants and babies. If not, special measures are taken for the bodies of infants and babies.

**PFE 4 Systems are in place to protect the quality and integrity of bodies, body parts, tissues and cells during transport and delivery to a destination**

- There are documented procedures for transportation of bodies and tissue anywhere outside the mortuary (e.g. lab, other establishment), including record-keeping requirements.
- There are written agreements in place with any external parties (e.g. undertaker, or courier) who transport bodies and/or tissue behalf of the establishment (laboratory or mortuary).

*(Note that coroners usually have their own agreements with external parties for transportation bodies and tissue; however, documentation for traceability purposes must still be maintained by the establishment for these cases.)*

**PFE5 Equipment is appropriate for use, maintained, quality assured, validated and where appropriate monitored**

- Items of equipment in the mortuary are in a good condition and appropriate for use:
  - fridges / Freezers
  - hydraulic trolleys
  - post mortem tables
  - hoists
  - saws (manual and/or oscillating)
  - PPE for high risk cases (e.g. respirators)
- The use of porous materials is kept to a minimum and has been risk assessed
- Maintenance/service records are kept for equipment, including fridges/freezers, trolleys, post mortem tables (if downdraught) and post mortem suite ventilation.

*(Note: These records may be held by the mortuary or centrally by the Trust, e.g. Estates Department.)*

**Disposal Standards**

**D1 There is a clear and sensitive policy for disposing of human organs and tissue**

- There is a documented Trust or mortuary/laboratory policy for the disposal of human tissue, which reflects the requirements of the HTA code of practice on disposal.
- There are documented procedures for disposal of human tissue, including blocks and slides.

**D2 The reason for disposal and the methods used are carefully documented**

- There are systems in place that ensure tissue is disposed of in accordance with the documented wishes of the deceased person's family.
- Disposal records include the date, method and reason for disposal.
- Tissue is disposed of in a timely fashion.

*(Note: this means that tissue is disposed of as soon as reasonably possible once it is no longer needed, e.g. when the coroner's or police authority ends or consented post-mortem examination is complete.)*

## Appendix 3: Classification of the level of shortfall

Where the HTA determines that a licensing standard is not met, the improvements required will be stated and the level of the shortfall will be classified as 'Critical', 'Major' or 'Minor'. Where the HTA is not presented with evidence that an establishment meets the requirements of an expected standard, it works on the premise that a lack of evidence indicates a shortfall.

The action an establishment will be required to make following the identification of a shortfall is based on the HTA's assessment of risk of harm and/or a breach of the HT Act or associated Directions.

### 1. Critical shortfall:

A shortfall which poses a significant risk to human safety and/or dignity or is a breach of the Human Tissue Act 2004 (HT Act) or associated Directions

*or*

A combination of several major shortfalls, none of which is critical on its own, but which together could constitute a critical shortfall and should be explained and reported as such.

A critical shortfall may result in one or more of the following:

- (1) A notice of proposal being issued to revoke the licence
- (2) Some or all of the licensable activity at the establishment ceasing with immediate effect until a corrective action plan is developed, agreed by the HTA and implemented.
- (3) A notice of suspension of licensable activities
- (4) Additional conditions being proposed
- (5) Directions being issued requiring specific action to be taken straightaway

### 2. Major shortfall:

A non-critical shortfall that:

- poses a risk to human safety and/or dignity, or
- indicates a failure to carry out satisfactory procedures, or
- indicates a breach of the relevant CoPs, the HT Act and other relevant professional and statutory guidelines, or
- has the potential to become a critical shortfall unless addressed

*or*

A combination of several minor shortfalls, none of which is major on its own, but which, together, could constitute a major shortfall and should be explained and reported as such.

### 3. Minor shortfall:

A shortfall which cannot be classified as either critical or major, but which indicates a departure from expected standards.

This category of shortfall requires the development of a corrective action plan, the results of which will usually be assessed by the HTA either by desk based or site visit.

## **Follow up actions**

A template corrective and preventative action plan is available as a separate Word document. You must complete this template and return it to the HTA within 14 days of the issue of the final report.

Based on the level of the shortfall, the HTA will consider the most suitable type of follow-up of the completion of the corrective and preventative action plan. This may include a combination of

- a follow-up site-visit inspection
- a request for information that shows completion of actions
- monitoring of the action plan completion
- follow up at next desk-based or site-visit inspection.

After an assessment of your proposed action plan you will be notified of the follow-up approach the HTA will take.